Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ECTOR COUNTY HOSPITAL DISTRICT
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
Texas Mutual Insurance Company Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-4356-01

MFDR Date Received
September 8, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is $3,488.82, minus the 10% the Beechstreet contract which applies for this date of service, minus their payment of $2,098.46 there is still an outstanding balance of $1,030.86."

Amount in Dispute: $1,030.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Texas Mutual believes it owes an additional payment of $1,767.99, i.e. $2098.46 - $330.77, and is willing to enter into a settlement agreement for that amount."

Response Submitted by: Texas Mutual Insurance Company Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 13 through 15, 2009	Outpatient Hospital Services	$1,030.86	$1,030.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

5. 28 Texas Administrative Code §102.4 sets out general rules regarding communications.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 25, 2009

- CAC – 85 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
- CAC – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- CAC – 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED
- CAC – 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- 198 – ALLOWANCE WAS REDUCED AS PER CONTRACTUAL AGREEMENT.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE PLUS A MARKUP.
- 494 – HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED TO MEDICARE'S METHODOLOGY PLUS A MARKUP PER THE TEXAS FEE SCHEDULE.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 728 – DENIED IN ACCORDANCE OF NETWORK CONTRACT THAT REQUIRED HCP TO BILL WITHIN STATE REGULATIONS. PLUS CCI EDITS. FOR INFO 800-381-8067
- 729 – CONTRACT APPLIED BY TEXAS STAR NETWORK. FOR INFORMATION PLEASE CALL 1-800-381-8067

EXPLANATION OF BENEFITS DATED APRIL 13, 2010

- CAC – 85 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
- CAC – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- CAC – 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- CAC – 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- 198 – ALLOWANCE WAS REDUCED AS PER CONTRACTUAL AGREEMENT.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE PLUS A MARKUP.
- 494 – HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED TO MEDICARE'S METHODOLOGY PLUS A MARKUP PER THE TEXAS FEE SCHEDULE.
- 615 – PAYMENT FOR THIS SERVICE HAS BEEN REDUCED ACCORDING TO THE MEDICARE MULTIPLE SURGERY GUIDELINES.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 723 – SUPPLEMENTAL PAYMENT AFTER RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK, FOR INFORMATION CALL 800-381-8067
- 724 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. PRIMARY NETWORK CONTRACT APPLIED BY FOCUS/BEECH STREET.
- 729 – CONTRACT APPLIED BY TEXAS STAR NETWORK. FOR INFORMATION PLEASE CALL 1-800-381-8067
- 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS/BEECH STREET.

EXPLANATION OF BENEFITS DATED JUNE 7, 2010

- CAC – 85 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
- CAC – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- CAC – W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- CAC – 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- CAC – 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- 198 – ALLOWANCE WAS REDUCED AS PER CONTRACTUAL AGREEMENT.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE PLUS A MARKUP.
- 494 – HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED TO MEDICARE'S METHODOLOGY PLUS A MARKUP PER THE TEXAS FEE SCHEDULE.

- 615 – PAYMENT FOR THIS SERVICE HAS BEEN REDUCED ACCORDING TO THE MEDICARE MULTIPLE SURGERY GUIDELINES.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 723 – SUPPLEMENTAL PAYMENT AFTER RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK, FOR INFORMATION CALL 800-381-8067
- 724 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. PRIMARY NETWORK CONTRACT APPLIED BY FOCUS/BEECH STREET.
- 729 – CONTRACT APPLIED BY TEXAS STAR NETWORK. FOR INFORMATION PLEASE CALL 1-800-381-8067
- 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS/BEECH STREET.

EXPLANATION OF BENEFITS DATED JULY 15, 2010

- CAC – 85 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
- CAC – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- CAC – W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- CAC – 131 – CLAIM SPECIFIC NEGOTIATED DISCOUNT.
- CAC – 193 ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC – 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE PLUS A MARKUP.
- 494 – HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED TO MEDICARE'S METHODOLOGY PLUS A MARKUP PER THE TEXAS FEE SCHEDULE.
- 723 – SUPPLEMENTAL PAYMENT AFTER RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK, FOR INFORMATION CALL 800-381-8067
- 724 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. PRIMARY NETWORK CONTRACT APPLIED BY FOCUS/BEECH STREET.
- 729 – CONTRACT APPLIED BY TEXAS STAR NETWORK. FOR INFORMATION PLEASE CALL 1-800-381-8067
- 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS/BEECH STREET.
- 820 – REIMBURSEMENT IS BEING ALLOWED BASED UPON A DISPUTE.

ISSUES

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code CAC – 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 22, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the healthcare provider had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. No documentation was found to establish time of notification in accordance with §133.4(f). The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific

amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415, date of service October 13, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
   - Procedure code 80053, date of service October 13, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $15.44. 125% of this amount is $19.30. The recommended payment is $19.30.
   - Procedure code 85025, date of service October 13, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.35. 125% of this amount is $14.19. The recommended payment is $14.19.
   - Procedure code 81000, date of service October 13, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.63. 125% of this amount is $5.79. The recommended payment is $5.79.
   - Per Medicare policy, procedure code 88311 may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
   - Per Medicare policy, procedure code 88304 may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
   - Procedure code 71020, date of service October 13, 2009, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.82. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of $26.38. The non-labor related portion is 40% of

the APC rate or $17.88. The sum of the labor and non-labor related amounts is $44.26. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $44.26. This amount multiplied by 200% yields a MAR of $88.52.

- Procedure code 20999 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0049, which, per OPPS Addendum A, has a payment rate of $1,438.83. This amount multiplied by 60% yields an unadjusted labor-related amount of $863.30. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of $849.23. The non-labor related portion is 40% of the APC rate or $575.53. The sum of the labor and non-labor related amounts is $1,424.76. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $1,424.76. This amount multiplied by 200% yields a MAR of $2,849.52.
- Procedure code 23929 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0129, which, per OPPS Addendum A, has a payment rate of $105.54. This amount multiplied by 60% yields an unadjusted labor-related amount of $63.32. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of $62.29. The non-labor related portion is 40% of the APC rate or $42.22. The sum of the labor and non-labor related amounts is $104.51. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line, including multiple-procedure discount, is $52.26. This amount multiplied by 200% yields a MAR of $104.52.
- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270, date of service October 4, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 0768, which, per OPPS Addendum A, has a payment rate of $0.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.14. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of $0.14. The non-labor related portion is 40% of the APC rate or $0.10. The sum of the labor and non-labor related amounts is $0.24 multiplied by 16 units is $3.84. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total APC payment for this line is $3.84. This amount multiplied by 200% yields a MAR of $7.68
- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690, date of service October 15, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005, date of service October 13, 2009, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of $26.09. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.65. This amount multiplied by the annual wage index for this facility of 0.9837 yields an adjusted labor-related amount of $15.39. The non-labor related portion is 40% of the APC rate or $10.44. The sum of the labor and non-labor related amounts is $25.83. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $25.83. This amount multiplied by 200% yields a MAR of $51.66.

- Procedure code 99218 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99218, date of service October 15, 2009, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.

4. The total allowable reimbursement for the services in dispute is $3,144.93. The amount previously paid by the insurance carrier is $2,098.46. The requestor is seeking additional reimbursement in the amount of $1,030.86. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,030.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,030.86, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.